

PATIENT REGISTRATION FORM

2010

**Today's Date:

Clinic Name: ASSOCIATED UROLOGIST 192

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: *First Name: Middle Initial:

*Address:

City: State: Zip:

Home Phone #: *Social Security #:

*Date of Birth: Age: *Sex: Marital Status: Drivers Lic#:

*Employer Name and Address:

Work Phone #:

E-mail Address: Cell Phone #:

Emergency Contact Name: Emerg Phone #:

Please tell us how you heard about us:

Referred by

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self Spouse Parent Other

*Last Name: *First Name: Middle Initial:

*Address:

City: State: Zip:

Home Phone #: *Social Security #:

*Date of Birth: Age: *Sex: Female Male

*Employer Name and Address:

Work Phone #:

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: *Insured's Name:

Insured's Social Security #: *Insured's Date of Birth:

*Policy / ID #: *Group #: Eff Date:

Claims Address & Phone:

SECONDARY INSURANCE:

Plan Name: *Insured's Name:

*Insured's Social Security #: *Insured's Date of Birth:

*Policy / ID #: *Group #: * Eff Date:

Claims Address & Phone:

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

**PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS**

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MedicalEdge Healthcare Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the MedicalEdge Healthcare Group Patient Information Privacy Policy. I hereby authorize MedicalEdge Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a MedicalEdge Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MedicalEdge Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

ASSOCIATED UROLOGISTS, P.A.

ADULT & PEDIATRIC UROLOGY • IMPOTENCY & INFERTILITY

(972) 270-8859 Answered 24 Hours • Fax (972) 279-5551

PRESCRIPTION REFILL PROCESS

When you need a prescription refill:

1. Call your pharmacy and request the refill (regardless of the number of refills left on your bottle). Please allow 72 hours for Associated Urologists to process your request from your pharmacy.
2. If it has been over 90 days since you were last seen by your Associated Urologists Physician, please call for a follow-up Appointment prior to your medication refill.

NON-CANCELLATION POLICY

In an effort to improve the quality of care we want to provide to all of our patients, there will be a \$35.00 office charge for patients who miss their appointments without a 24-hour advanced notice to our office. It is our belief this policy will minimize the amount of valuable unused appointment time that could have been given to our patients with acute illnesses. We strive to provide all our patients the best care possible and we believe this policy will move us closer to our goal.

ANCILLARY SERVICES

I acknowledge that my treating physician may have financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

Thank you for your help in making Associated Urologists a most effective Patient Care Facility.

Associated Urologists Physicians and Staff

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Associated Urologists

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

12/06

Associated Urologists
841 Wheatfield Dr. Ste. 100
Sunnyvale, TX 75182

Clinic: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient
Name: _____

Date
of Birth: _____

Date
of Visit: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____
(please sign here - Patient or Responsible Party)

Date: _____

Responsible
Party Name: _____
(please print name of Responsibility Party if different from Patient)

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

Social Security No. _____ DATE OF BIRTH ____/____/____ Referred By _____

CHIEF COMPLAINT _____ OCCUPATION: _____ Primary Care Physician: _____
 What is the main reason for your visit today? (Describe your problem in detail) _____

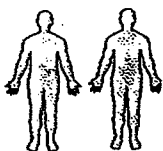
History of Present Illness (Urologic)

Please answer the following questions

Location of the problem

Abdomen _____ Back _____ Leg _____
 Other _____

Front Back



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago _____ 2 weeks ago _____ 1 month ago _____
 Other _____

Does anything help or make the problem worse?

Moving around _____ Standing Up _____ Lying on my side _____
 Other _____

How long does the problem last?

30 minutes _____ 1 hour _____ It is always there _____
 Other _____

Is anything else occurring at the same time?

Yes _____ No _____ If yes, please explain.
 Nausea _____ Rash _____ Headaches _____
 Other _____

Is the problem constant or variable?

Dull then Sharp _____ Very sharp then leaves _____ Always there _____
 Other _____

Does the problem interfere with your normal functions?

Yes _____ No _____ If yes, please explain _____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

List all personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery _____ Date _____

Are you on any medications? Y _____ N _____ (If yes, list all.)

Are you on a special diet? Y _____ N _____ (If yes, please explain)

Do you smoke? Y _____ N _____

If yes, how much? _____

Do you drink? Y _____ N _____

If yes, how much? _____

Do you have allergies? Y _____ N _____ (If yes, Please explain.)
 (including allergy medications)

Physician use only: (Comments/Notes)

# Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

ASSOCIATED UROLOGISTS

**Asif Syed, M.D., Nabeel Syed, M.D., Robert A. Bloom, M.D.
Kelli Whitehead, A.R.N.P., Steven Edwards, P.A.**

**2540 N. Galloway Avenue, Suite 103
Mesquite, Texas 75150
Phone: 972/270-8859 Fax: 972/279-5551**

Name: _____
Age: _____
Date: _____

Urologic History

How many times a day do you urinate (from the time you get up in the morning until you go to sleep at night)? _____

How many times a night do you urinate (from when you go to bed sleep at night until you get up in the morning)? _____

Please Answer YES or NO To The Following:

Does it hurt or burn when you urinate? _____

Have you recently seen blood in your urine (Red Urine)? _____

When you go to the bathroom do you have to wait more than 5-10 seconds before you start to urinate? _____

Is your urine stream weak or does it dribble? _____

Does your stream slow down or stop in the middle instead of flowing continuously? _____

Does your urine stream dribble a lot at the end? _____

Do you strain or push to pass urine? _____

Do you feel like your bladder empties completely? _____

When you need to urinate, is the feeling intense or do you have a lot of urgency? _____

Do you ever wet yourself before getting to the bathroom to urinate (even a drop or two)? _____

Do you wet yourself after urinating? _____

Do you ever wet yourself if you cough, sneeze, laugh, or lifting something? _____

Do you have pain?

- a) **In the area around your bladder (lower abdomen)** _____
- b) **In your sides** _____
- c) **In your back** _____
- d) **(MEN) in your testes** _____
- e) **(WOMEN) with intercourse** _____

Adult and Pediatric Urology

PATIENT'S NAME:

DATE:

Have you had fever or chills recently? _____

Have you had an infection in your urine (bladder or kidney)? _____

Have you ever had a sexually transmitted disease: gonorrhea (the clap),
Chlamydia, syphilis, herpes, warts or AIDS? _____

Have you ever had kidney stones? _____

Do you have any children? If yes how many? _____

For MEN: Do you have erection problems? _____

PAST HISTORY

Have you ever been treated by a urologists before?
-If yes, when, by whom and why?

Have you ever had a catheter (tube), metal rod or instrument passed up
your urethra (urine channel)? _____

Are you a "free bleeder" (do you bleed even without being cut
or do you bleed for a long time if you are cut)? _____

Do you take aspirins frequently (how many a month)? _____

PATIENT NAME: _____

DATE: _____

REVIEW OF SYSTEMS

Do you now or have had **RECENTLY** any problems related to the following systems?
 Yes or No. Please explain any yes answers in space provided

Constitutional Symptoms
 Fever Y N
 Chills Y N
 Headache Y N
 Other _____
Eyes
 Blurred Vision Y N
 Double Vision Y N
 Pain eye Y N
 Other _____
Allergic/Immunologic
 Hay Fever Y N
 Drug allergies Y N
 Other _____
Neurological
 Tremors Y N
 Dizzy spells Y N
 Numbness/tingling Y N
 Blood clot(s) to lungs Y N
 Seizures Y N
 Other _____
Endocrine
 Excessive thirst Y N
 Too hot/cold Y N
 Tired/sluggish Y N
 Other _____
Gastronintestinal
 Abdominal Pain Y N
 Nausea/Vomiting Y N
 Indigestion/Heartburn Y N
 Difficulty swallowing Y N
 Constipation or diarrhea Y N
 Hemorrhoid Y N
 Blood with vomiting in stools Y N
 Other _____
Cardiovascular
 Chest pain Y N
 Varicose veins Y N
 High blood pressure Y N
 Swelling of ankles Y N
 Other _____

Integumentary
 Skin rash Y N
 Boils Y N
 Persistent itch Y N
 Other _____
Musculoskeletal
 Joint pain Y N
 Neck pain Y N
 Back pain Y N
 Other _____
Ear/Nose/Throat/Mouth
 Ear infection Y N
 Sore throat Y N
 Sinus problems Y N
 Difficulty hearing or deafness Y N
 Ear infection or discharge Y N
 Nose bleeds Y N
 Other _____
Genitourinary
 Urine retention Y N
 Painful urination Y N
 Urinary frequency Y N
 Other _____
Respiratory
 Wheezing Y N
 Frequent cough Y N
 Shortness of breath Y N
 Other _____
Hematologic/Lymphatic
 Swollen glands Y N
 Blood clotting problem Y N
 Other _____
Psychologic
 Are you generally satisfied with your life? Y N
 Do you feel severely depressed? Y N
 Have you considered suicide? Y N
 Other _____

Physician use only: (Comments/Notes)	
#/Answer	Level of
Service	
0-1	1 or 2
2-9	3
10+	4 or 5